STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING _____ B. WING _____	C 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	**10312 ALLISONVILLE RD FISHERS, IN 46038**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00164673.

Complaint IN00164673 Unsubstantiated due to lack of evidence.

Survey date: February 11, 2015

Facility Number: 012466
Provider Number: 155786
AIM Number: 201014060

Survey Team:
Mary Jane G. Fischer RN TC

Census Bed Type:
SNF: 36
SNF/NF: 110
Total: 146

Census Payor Type:
Medicare: 36
Medicaid: 91
Other: 19
Total: 146

Sample: 4

Allisonville Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint Number IN00164673.

Quality Review 02/12/15 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE